

Kaposi's sarcoma, were documented. Our experience with this disease started from that point.

Traditionally the medical community has considered Kaposi's sarcoma a systemic disease with no single regimen known to date to guarantee cure. Most therapy regimens have been directed towards palliation. The disease being endemic in Africa where radiotherapy is a relatively new modality of cancer treatment the favoured palliative treatment has involved different programmes of chemotherapy with single drugs and more recently with various combinations involving DTIC, Vincristine, methotrexate and vinblastine among others. Radiotherapy as a systemic palliative treatment is not a new innovation either. Whole body irradiation has been used in leukemias and lymphomas since many years. Half body radiotherapy is a more recent mode of radiotherapy delivery. Initial experience with this style of treatment was with advanced metastatic cancers typically those of the breast and prostate. Initial experience with higher doses than 800r per session had severe complications and fatalities. 600r session seems today as a fairly tolerable dose. We have used 600r scheme since 1980 for patients with endemic Kaposi's sarcoma. Our experience with endemic Kaposi's sarcoma patients will be communicated in a different paper. Our good success with endemic Kaposi's sarcoma irradiation prompted the use of half body irradiation in epidemic Kaposi's sarcoma.

Literature has scanty information on irradiation of Kaposi's sarcoma. From their experience, Milan et al concluded that extended radiotherapy gave superior results to local treatment. Experience from Cooper Harris, and Nisce all attest to the palliative benefit of radiotherapy in Kaposi's sarcoma. Half-body radiotherapy is a convenient method of treatment delivery involving only one exposure every 4 weeks. It can be given on outpatient basis and it is a lesser burden to a busy radiotherapy unit. Toxicity from the treatment is minimal with transient nausea and vomiting being the only bothersome concern. In Africa where the cost of chemotherapy might be beyond the means of an evolving cancer treatment unit radiotherapy has a definite relevance.

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AIDS IN DENTISTRY

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AIDS is a disease that has had to have everyone interested, from the medical profession, barbers etc and the general public. This disease's mode of transmission is not unusual but the fact that there is no known cure makes it frightening.

The realisation that the world could possibly witness the gradual dwindling or even loss of youth of a particular age group that is susceptible to the disease - adolescence and concomitant behavioural changes notwithstanding - has sinister implications.

The Dental profession and the medical profession should take a leading role in the understanding of the disease and its behaviour and control or elimination of its spreading.

There are three main areas where the dental profession should particularly take interest. This does not mean that this should be done in isolation but in close collaboration with other relevant medical disciplines.

Infection Control

There has been laxity in standards of infection control not only in dental clinics but in general health care system. From the knowledge that HIV can be destroyed by proper sterilization techniques, interest has been taken in imposing the high standards of infection control in hospitals. But in our situation in Tanzania the means are not always there and yet the service has to continue. So there is a need for us to examine the most efficient but realistic ways of infection control in our daily work. The profession is one of the most vulnerable medical disciplines as bleeding is inevitable in most of our clinical procedures. With the threat of the incurable HIV infection, proven methods of sterilization and institution of infection barriers have to be established and get adhered to. Anything less may mean danger of loss of life to professional personnel, and patients.

In developing countries the problem of adhering to the highest standards of infection control is caused by financial constraints. In these circumstances it is essential to investigate methods that are effective but within the means of our health institutions. For example the prototype pressure sterilizer is now available cheaper and can be used even where electricity is not available.

Besides lack of equipment and materials, lack of knowledge of infection control and for those with knowledge carelessness and irresponsibility are just as dangerous threats to spread of HIV infection. So while demanding for infection control facilities every effort must be made at the same time to educate and motivate clinicians to practice stringent methods of infection control within our means.

There is need for guidelines to be established and get well understood by everyone who provide health care. This will need to be formulated by a panel of experts who understand our situation. The recommendations of the experts with govern-